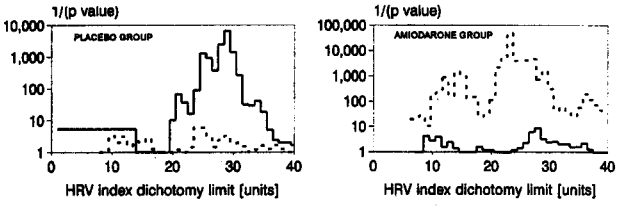
of cardiac mortality with reduction of 24-hour HRV was examined in both Amiodarone and Placebo groups.



The results (Figures: full line = arrhythmic mortality, dashed line = non-arrhythmic mortality) show that while in Placebo group, reduced HRV was strongly associated with arrhythmic but not non-arrhythmic mortality, the opposite was true in the Amiodarone treated group. Thus the study confirms that also in patients with reduced LVEF, HRV is a strong predictor of arrhythmic mortality. The study further suggests that some patients who would die an arrhythmic death suffer a non-arrhythmic death when on Amiodarone.

1078-122 Identification and Management of High-Risk Patients With Acute Myocardial Infarction: The National Registry of Myocardial Infarction

M. Burns, R.C. Becker, J.M. Gore, C. Lambrew, W. French, W. Rogers for the National Registry of Myocardial Infarction (NRMI-2) Investigators. *University of Massachusetts Medical School, Worcester, MA, USA*

High standards of cost-effective medical care require practical methods for risk stratification and timely appropriation of available treatments. The NRMI-2 Risk Assessment was validated using a database including over 200,000 patients with myocardial infarction (MI). Independent predictors of an adverse in-hospital outcome were: Killip IV (OR 4.46), systolic BP < 100, pulse > 100 (OR 2.0) Killip III (OR 1.59), age > 70 years (OR 1.42), Killip II (OR 1.41), ST elevation on initial ECG (OR 1.32), anterior site of MI (OR 1.23) and prior MI (OR 1.10) (all $p < 0.001$ except age $p < 0.01$). Thrombolytics (47.5 vs 18.6%; $p = 0.0001$) and either 1º PTCA or emergent CABG (9.3 vs 5.1%; $p = 0.0001$) were utilized more often in the early management of high than low-risk patients. Door-to-drug (91 versus 62 minutes; $p = 0.0001$), door-to-balloon (247 versus 161 minutes; $p = 0.0001$) and door to bypass (439 versus 300 minutes; $p = 0.0001$) times were all lower in high-risk patients. Mortality among high-risk patients receiving thrombolytic tx (n = 26,367) 1º PTCA/CABG (n = 5,181) and those without reperfusion (n = 23,973) was 8.1%, 10.3%, and 21.4%, respectively ($p = 0.0001$). Risk stratification is possible using readily available demographic, ECG and clinical information. The NRMI-2 Risk Assessment Assignment provides insight into health care trends in the U.S.

1078-123 Vagal Reflexes and Left Ventricular Function in Post-Myocardial Infarction Patients: Results from the ATRAMI Study

M.T. La Rovere, A. Mortara, S.H. Hohnloser, J.T. Bigger, Jr., F.I. Marcus, R. Nohara, P.J. Schwartz for the ATRAMI Investigators. *"S. Maugeri" Foundation, IRCCS, Montescano Pavia, Italy, University of Pavia, Italy*

Unequivocal data have shown that Baroreflex Sensitivity (BRS) is depressed in post myocardial infarction patients but whenever is logical to assume that the larger the infarct size the lower the baroreceptors' response, the relationship between the autonomic derangement and ventricular function has not been fully elucidated. In the ATRAMI (Autonomic Tone and Reflexes After Myocardial Infarction) study 1176 out of 1284 patients had both BRS (phenylephrine method) and LVEF (Echo, Anglo or MUGA) (mean BRS 7.2 ± 4.9 ms/mmHg, LVEF 49 ± 2%) measured within one week. The correlation between BRS and LVEF, as well as between BRS and CPK levels (n = 1026) was weak (respectively, $r = 0.17$ and $r = 0.08$). However, when LVEF was categorized in 3 groups (≤ 35, 36–50, > 50%), a more depressed BRS was detected in the lowest LVEF group (4.9 ± 3.8 vs 7.4 ± 4.8 and vs 7.7 ± 5, both $p < 0.001$) and the number of patients with a markedly depressed BRS (< 3 ms/mmHg) was significantly higher among patients with reduced LVEF as compared to patients with LVEF 36–50% and > 50% (34% vs 14% and 11% respectively, $p < 0.01$). In the ATRAMI study survival analysis showed the depressed BRS (< 3 ms/mmHg) and reduced LVEF (≤ 35%) were both independent predictors of survival (Multivariate RR 2.8 (95% CI 1.2–6.1) for BRS and RR 4.7 (95% CI 2.0–10.8) for LVEF). Moreover the presence of both depressed LVEF and BRS significantly increased the RR to 13.4 (95% CI 6.6–27.4).

Conclusion: In post-MI patients baroreflex activity is weakly related to the extent of ventricular damage as measured by LVEF. Both indexes of ventricular and autonomic dysfunction are independently associated with a poor prognosis and the combination of BRS and LVEF is of meaningful value in the identification of patients at increased risk for cardiac mortality.

1078-124 In-hospital Adverse Cardiac Events Following First Myocardial Infarction Are Similar Among African-Americans and Caucasians

F. Khaja, H.N. Sabbah, M. Alam, G. Divine, S. Borzak, S. Smith, K.G. Richer-Cornish, S. Goldstein. *Henry Ford Heart and Vascular Institute, Detroit, MI, USA*

It is generally believed that African-Americans (AA) experience greater adverse cardiac events following an acute myocardial infarction (AMI) compared to Caucasians (C). In the present study, we prospectively examined the in-hospital adverse cardiac events in a cohort of 392 consecutive patients (125 AA and 267 C) with a first AMI admitted to the cardiac intensive care unit during a period of 4 years. A patient was considered to have had an adverse cardiac event if one of the following occurred during the index hospitalization: death, ventricular fibrillation (VF) or ventricular tachycardia (VT), pulmonary congestion (PC) or cardiogenic shock (CS), reinfarction (RI) or post-infarction angina (PIA).

	AA (%)	C (%)	Relative Risk and 95% Confidence Interval	P-value
Death	6	3	1.42 (0.52, 3.91)	0.49
VF or VT	8	10	0.79 (0.40, 1.58)	0.51
PC or SC	21	20	1.03 (0.68, 1.56)	0.90
RI or PIA	22	20	1.13	(0.75, 1.69) 0.56
Any Event	37	42	0.87 (0.66, 1.14)	0.30

The data indicate that, following first AMI, in-hospital adverse events are not statistically different between AA and C. This lack of difference between races is maintained even after adjusting for age and gender (Cox regression). We conclude that AA experience similar rates of in-hospital adverse cardiac events after a first AMI as C.

1078-125 Chlamidia Pneumoniae Infection and Atherosclerotic Coronary Disease

M. Penco, R. Sessa, M. Di Pietro, A. Varveri, G. Aurigemma, F. Fedele, M. Del Piano, A. Dagianti. *Department of Cardiovascular and Respiratory Sciences and Department of Microbiology, La Sapienza University, Rome, Italy*

Objectives: The aim of this study was to assess the incidence of Chlamidia pneumoniae antibodies in patients with angiographically verified atherosclerotic coronary artery disease (CAD). *Methods:* 114 consecutive patients were investigated between April 1994 and June 1995. Patients were divided into two groups: one of 72 patients with acute myocardial infarction (AMI) (53 men, 19 women, mean age 62.57 ± 10.12), the other of 42 patients with chronic ischemic heart disease (37 men, 5 women, mean age 62.75 ± 9.26). Identification of Chlamidia pneumoniae was carried out with the micro immunofluorescence method (Alifax), on serum samples taken from patients on the day after admission to the hospital. The IgG and IgA anti-Chlamidia pneumoniae titre was assessed, values > 1.32 and > 1:8 being respectively considered significant. *Results:* out of 72 patients with AMI, 67.9% and 37.7% of the 53 men had a significantly high IgG and IgA titre respectively; out of 19 women 31% and 15.8% had a significantly high IgG and IgA titre respectively. Out of 42 patients with chronic ischemic heart disease, 45.9% and 35% of the 37 men had a significantly high IgG and IgA titre respectively; only one woman out of 5 had a high IgG and IgA titre. *Conclusion:* These data show that after AMI, in a high percentage of patients there is an abnormally high antibody IgG and IgA titre, the former being more significant. A high antibody titre in a smaller percentage of patients in the group with chronic ischemic heart disease suggests that there may be an exacerbation of Chlamidia pneumoniae infection during AMI, but these data do not provide evidence of a direct link and a clear relationship between Chlamidia pneumoniae infection and clinical symptoms of atherosclerotic coronary disease.

1078-126 Determinants of Long Term Cardiovascular Drug Use After Myocardial Infarction: Does Country Make a Difference?

A.M. Ross, J.S. Reiner, K.S. Coyne, Y.C. Draoui, C.F. Lundergan. *The George Washington University, Washington, DC, USA*

International clinical trials have uncovered substantial differences in adjunctive treatments post myocardial infarction (MI) between countries despite rapid information exchange between continents. We examined 2 year follow-up data from 1846 patients in the GUSTO-1 angiographic study to identify